Statement of Charles P. Blahous

Public Trustee for the Medicare Trust Funds[1]

Before the Subcommittee on Health

of the U.S. House of Representatives Committee on Ways and Means

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Thank you, Mr. Chairman, Mr. Ranking Member, and all of the members of the subcommittee. It is as always a great honor to appear before you to discuss the findings of the 2013 annual report of the Boards of Trustees for the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, more commonly known as the Medicare trust funds. By mutual agreement with my fellow Public Trustee, Dr. Robert Reischauer, I will present the primary findings of the Trustees' report with respect to projected Medicare finances. I will be leaving other important aspects of this topic, such as the reasons for changes since last year's report as well as the implications for Medicare of broader health care trends, to be covered in his testimony.

Medicare Trust Fund Operations and 2012 Data

Trust Funds: Medicare has two trust funds. The Hospital Insurance (HI) Trust Fund (sometimes known as Part A) helps to pay for hospital, home health following hospital stays, skilled nursing facility, and hospice care for the aged and disabled. Medicare's other trust fund is the Supplementary Medical Insurance (SMI) Trust Fund (which includes both Part B, a voluntary enrollment program of physician, outpatient hospital and home health services, and Part D, another voluntary program that provides prescription drug benefits). Medicare also has a Part C, the "Medicare Advantage" program, whose costs are paid from both the HI Part A and SMI Part B Trust Fund accounts. As is the case with Social Security, the HI and SMI Trust Funds contain special-issue Treasury bonds, which earn interest and provide a financing reserve that can be drawn upon whenever incoming dedicated revenues fall short of outgoing expenditures.

Although the income sources for Medicare as a whole are more varied than they are for Social Security, in significant respects the Trustees' projections for the HI Trust Fund specifically are analogous to those made for the Social Security program. As with Social Security, the majority of HI Trust Fund revenues are provided by a payroll tax levied upon worker wages and self-employment earnings. Also with respect to HI, the Trustees make an annual determination of whether there is an aggregate imbalance between projected program income and expenditures, as well as the date (if any) by which trust fund assets are projected to be depleted.

[1] I am also a research fellow with the Hoover Institution and a senior research fellow with the Mercatus Center.

By contrast, the finances of Medicare's SMI Trust Fund operate somewhat differently. Part B and Part D premiums and contributions from general revenues are re-established annually to cover expected costs. SMI is thus kept solvent essentially by statutory construction. Financial strains on the SMI side, therefore, are manifested not in a projected actuarial imbalance or a date of trust fund depletion, but in rising enrollee premiums and requirements of general government revenues.

Each year there is naturally public and press interest in our updated projection for the date of depletion of the Medicare HI Trust Fund. While this projection is important, it is but one piece of a much larger mosaic of Medicare program finances.

Income: For Part A, the largest source of income is a 2.9% tax upon wage earnings nominally split between employer and employee, though economists generally agree that both ends of the tax are paid from worker compensation. Unlike the Social Security payroll tax, the application of the Medicare tax is not capped by wage income level. Starting this year, single taxpayers with earnings over $200,000 and married couples over $250,000 are paying an additional 0.9% tax to the HI Trust Fund. Medicare also receives income from the taxation of Social Security benefits (up to 85% of such benefits are subject to the income tax for those above certain income levels, with taxation on 50% dedicated to Social Security and the remaining 35% to Medicare HI).

In Parts B and D, general revenues finance roughly 75 percent of total costs. Another significant portion of Part B revenues comes from beneficiary premiums. The standard Part B monthly premium for 2013 is $104.90. Higher-income beneficiaries (over $85,000 for individuals, $170,000 for married couples) pay higher Part B premiums. For Part D, individual monthly premium payments depend on the specific plan selected but average about $30 for standard coverage in 2013. As with Part B, higher-income beneficiaries in Part D are subject to higher income-related premiums. Part D also receives payments from States, covering about 12 percent of Part D costs in 2013.

Medicare Income Sources, Calendar Year 2012 ($ Billions)

	Part A	**Part B**	**Part D**	**Total**
Payroll taxes	205.7	0.0	0.0	205.7
Taxation of Soc. Sec. benefits	18.6	0.0	0.0	18.6
Premiums	3.4	58.0	8.3	69.8
Transfers from States	0.0	0.0	8.4	8.4
General revenue	0.5	163.8	50.1	214.4

Interest	10.6	2.8	0.0	13.4
Other	4.1	2.4	0.0	6.5
Total	**243.0**	**227.0**	**66.9**	**536.9**

Expenditures: Total Medicare expenditures in calendar year 2012 were roughly $574.2 billion, of which $565.9 billion were benefit payments and the remaining $8.3 billion administrative expenses. Categories of expenditures included $178.8 billion in hospital benefits (most of which were paid from Part A), $136.2 billion in Part C payments, $69.6 billion for physician fee schedule services (Part B), $66.5 billion in prescription drug payments (Part D), $28.0 billion for skilled nursing facilities (Part A), and $18.6 billion for home health care (Parts A and B), among other payments.

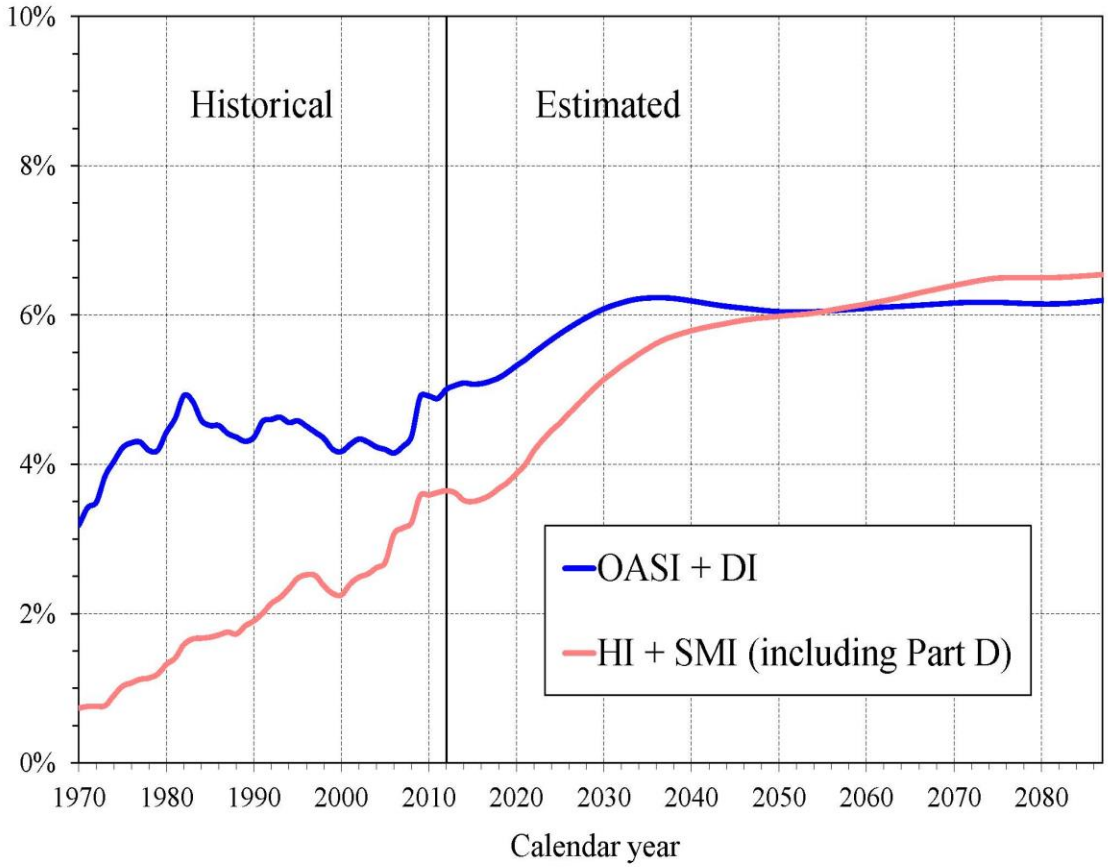
Because 2012 expenditures exceeded income in both the HI and SMI Trust Funds, total asset reserves in each fund declined. Holdings of the HI Trust Fund declined from $244.2 billion at the end of 2011 to $220.4 billion at the end of 2012. The SMI Trust Fund is smaller by statutory design because its financing is established annually to cover expected costs. Assets in the SMI Trust Fund declined from $80.7 billion at the end of 2011 to $67.2 billion at the end of 2012.

Medicare Financial Projections

Medicare costs are projected to rise substantially in future years relative to today's levels as shown on the following graph. The graph compares projected Medicare (HI + SMI) costs to Social Security (OASI + DI) costs as a percentage of GDP. In 2013 Medicare costs are estimated to be 3.62% of GDP. By 2035 they are projected to have risen substantially to 5.6% of GDP under current schedules and then to rise somewhat more slowly afterward to reach 6.5% of GDP in 2087.

In both Social Security and Medicare the vast majority of cost growth relative to GDP is projected to occur prior to the mid-2030s. The primary driver of this cost growth is demographic change. Under current-law eligibility criteria, the number of beneficiaries per taxpaying worker will rise markedly as the large baby boom generation leaves the workforce and joins the rolls of beneficiaries. The slope of cost growth is somewhat higher in Medicare than it is in Social Security because Medicare costs are also affected by medical cost inflation, which has tended to grow faster than general price inflation. For the next couple of decades, however, the primary driver of program cost growth will be the rise in the number of beneficiaries, with health cost inflation only becoming the relatively more important factor later in the long-range projection period.

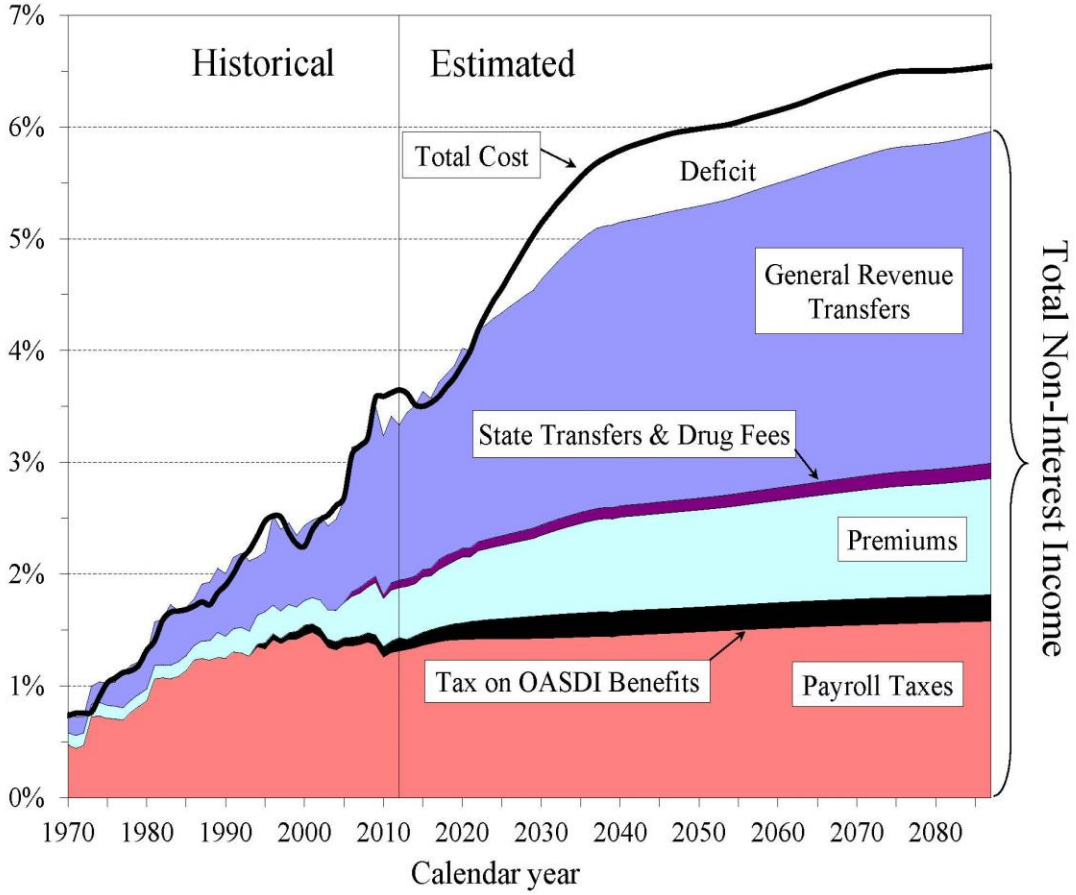
Social Security and Medicare Cost as a Percentage of GDP



Both of the aforementioned drivers of Medicare cost growth (population aging and general health care cost inflation) exemplify why it is generally preferable to enact program financing reforms sooner rather than later. Changes to health care expenditure growth are unlikely to be realized in the form of a sudden reduction in national health care costs, whereas earlier reforms that reduce the rate of cost growth can compound to produce substantial savings over the long term. Similarly, reforms to constrain the growth in the number of Medicare beneficiaries are better enacted sooner rather than later so as to give affected individuals more time to prepare for any legislated changes.

As Medicare costs grow over time, program financing resources are projected to change as shown in this graph reproduced from the summary of the annual reports.

Medicare Cost and Non-Interest Income by Source as a Percentage of GDP

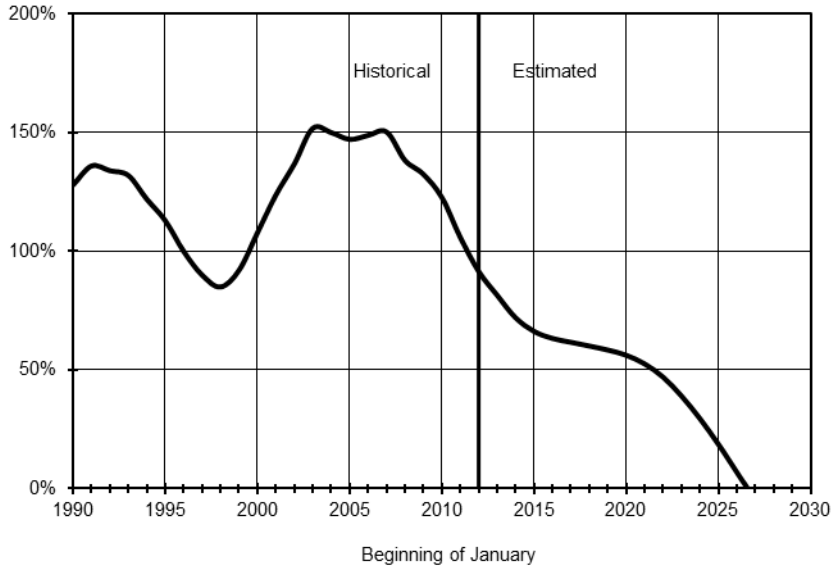


Under current projections this cost growth will exert substantially increased pressure on the general federal budget. General revenue transfers to support SMI payments, for example, would grow from 1.5 percent of GDP in 2013 to 2.9 percent in 2087. The share of total Medicare spending covered by dedicated taxes would fall from 39 percent in 2013 to 28 percent in 2087.

As mentioned earlier, the financing of Parts B and D of Medicare will be established annually to cover expected benefit payments irrespective of cost growth rates. The same is not true, however, with respect to Part A, Medicare's HI Trust Fund. There is no mechanism under current law for financing HI benefits in excess of HI Trust Fund resources. Such benefits can only be paid in full as long as the HI Trust Fund maintains a positive balance.

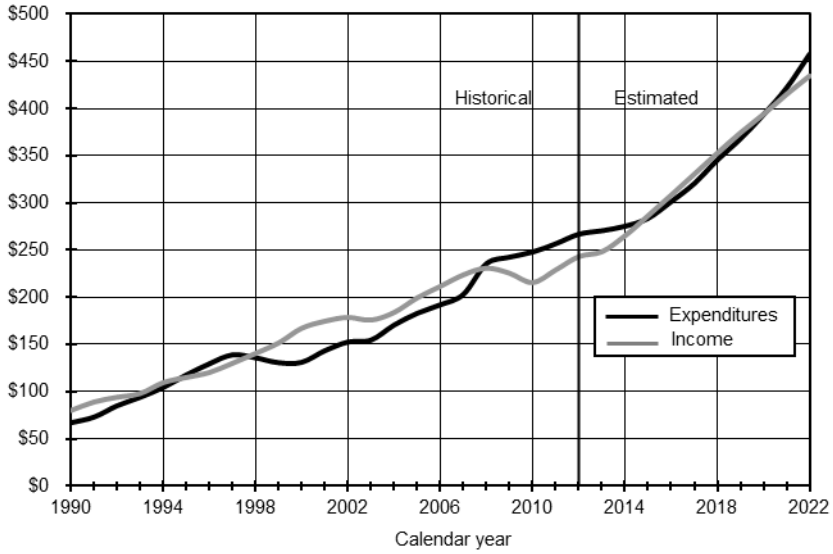
Under our current projections Medicare's HI Trust Fund would be depleted in 2026, at which point its income would be sufficient to finance 87 percent of program costs, a percentage that would decline to 73 percent by 2087. To date lawmakers have never allowed projections of HI Trust Fund depletion to be realized. Our current projection of 2026 is two years later than the projection made in last year's Trustees report.

Medicare HI Trust Fund Reserves as a Percentage of Expenditures



My colleague Dr. Reischauer will explain some of the reasons for the modest change in the projected HI Trust Fund depletion date. Here I will simply note that the pattern of trust fund financial flows is substantially different in Medicare HI than it is, for example, in Social Security. Social Security by contrast ran substantial surpluses in recent decades, amassing much larger trust fund reserves that it will draw upon, enabling the full payment of benefits during several years of substantial deficits of tax income relative to expenditures before its trust funds are depleted. Medicare HI instead has a comparatively smaller trust fund. Its balance at the start of this year represented the equivalent of only 0.81 years' worth of HI benefit payments. Thus the projection that its trust fund will continue to show a positive balance until 2026 depends on whether its tax and premium income will closely match outgoing benefit payments over the next several years as we currently project.

Past and Projected HI Income and Expenditures



Medicare finances are subject to greater projection uncertainty than are Social Security's because of the difficulty of projecting general health care cost inflation. Later in this testimony I will briefly describe our projection methods as well as some sources of projection uncertainty. Here I will simply note that modest inaccuracies in our projected growth rates could cause the projected HI depletion date to move by a few years. If, for example, our projections for annual HI cost growth are off by roughly half a percentage point per year, the projected depletion date could shift by two years. Under the Trustees' so-called "high-cost" scenario that assumes less favorable trends in economics, demographics and health cost inflation, the HI Trust Fund is depleted in 2019.

The Medicare Modernization Act of 2003 requires that the Board of Trustees determine each year whether the annual difference between program outlays and dedicated revenues exceeds 45 percent of total Medicare outlays in any of the first seven fiscal years of the projection period. The provision is intended to measure the extent to which rising Medicare costs are placing pressure on the general federal budget. When the Trustees make such a determination in two consecutive reports, a "Medicare funding warning" is triggered. This year's report projects the difference between outlays and dedicated financing revenues to exceed 45 percent of total Medicare outlays during fiscal year 2013, prompting a "Medicare funding warning" for the seventh straight year.

Methodology and Assumptions

The Trustees rely upon the same fundamental demographic and economic assumptions for the Medicare report as are used for the Social Security report. These assumptions are developed based on the recommendations of the Social Security Administration Office of the Chief Actuary, subject to review, possible alteration, and approval by the Trustees as a group. The

CMS Office of the Actuary in turn develops the recommendations for the assumptions with respect to future health care cost growth, again subject to review, possible alteration, and approval by the Trustees. As members of this subcommittee are well aware, health care experts often disagree on what to expect in health care cost inflation even over short-term periods, let alone over the 75-year valuation period over which the Trustees make projections. And while these variables are extremely difficult to predict with precision, they have a very large impact upon Medicare cost projections over the long run.

Our current projection methodology follows recommendations of the 2010-11 Medicare Technical Review Panel. The first step is essentially to estimate the rate of cost growth in the health sector overall. These projections are based on estimates of the elasticity of health care cost growth in response to changes in certain underlying factors that include medical prices, income levels, and levels of insurance coverage. Based on this methodology we project that total health care cost growth per capita will average 1 percent more than per-capita GDP growth annually over the 75-year valuation period. Importantly, this rate of growth is projected to decline over time. The rate is "GDP plus 1.15 percent" in 2037, and it gradually declines to "GDP plus 0.32 percent" by 2087. One technical explanation for the expected slowdown is that as medical prices rise and health care consumes a greater proportion of income, the demand for increased health care will lessen, which would exert downward pressure on future rates of health care spending growth. A layman's translation of this phenomenon is that we do not expect medical care spending to grow to the point where our economy is devoted to nothing other than health care. As has sometimes been said, we should not expect that in the future we will all be homeless, naked and starving but with impeccable health care. An important point to understand is that a certain amount of health care cost growth deceleration is built into our projections irrespective of the effects of Medicare legislation.

Projecting Medicare cost growth requires us to translate these estimates of overall health spending to take account of Medicare reimbursement rates. Pursuant to a recommendation from the Technical Review Panel, we assume that the input costs facing health care providers would increase roughly 0.4 percentage points faster than medical output prices. This 0.4 percentage point difference reflects an estimate based on the historical level of annual provider productivity improvements. This estimate in turn underlies the aforementioned assumption of GDP plus 1.0 percent for the overall health sector. In other words, we estimate that the health care sector reflecting just input costs but not health sector productivity will increase at GDP plus 1.4 percent on average over 75 years. Certain cost-saving provisions of the 2010 Affordable Care Act (ACA) are important for translating this GDP plus 1.4 percent estimate into estimates of Medicare cost growth. These provisions reduce payment updates to all Part A providers and most non-physician Part B providers by the 10-year moving average increase in private, nonfarm business multi-factor productivity growth, which is projected to be 1.1 percent annually. This by itself would reduce expected cost growth in these categories of Medicare services to GDP plus 0.3 percent annually, on average over 75 years. The Technical Panel further concluded that these provisions of the ACA would reduce health service volume and intensity growth by 0.1 percentage point annually, bringing our projection for total growth in these Medicare categories to GDP plus 0.2 percent over 75 years.

Again it is important to remain aware that this is an average growth rate over 75 years. Earlier in the valuation period we are projecting that per capita Medicare cost growth in these areas will be

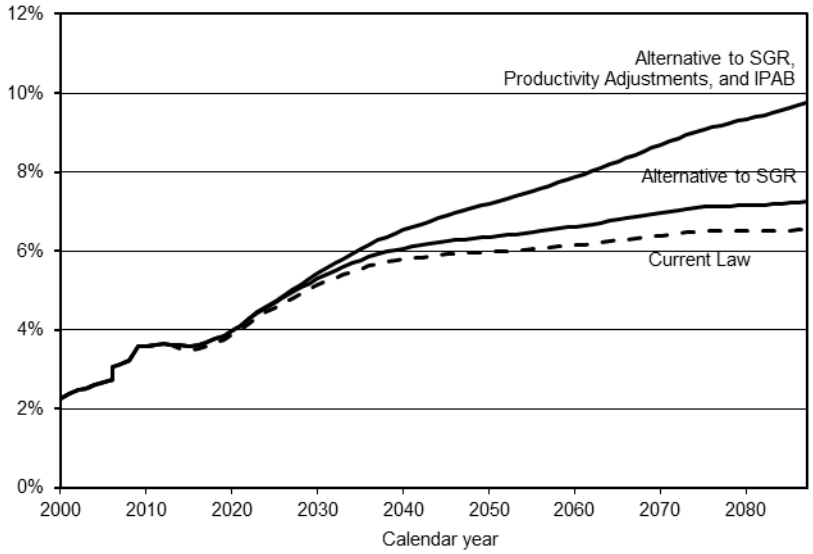
more rapid than per capita GDP growth, but less rapid later in the valuation period. Under our projections, costs for these HI and SMI Part B services will grow at a rate of "GDP plus 0.4 percent" in 2037 but slow to "GDP minus 0.5 percent" by 2087.

Total Medicare Costs Likely to be Higher than Projected Under Current Law

The contours of our long-term Medicare projections subsequent to the passage of the 2010 ACA have caused some to speculate that certain cost-saving provisions of the ACA may prove unsustainable over the long term and are likely to be overridden by future lawmakers. This concern is rooted in part in the observation that our projections show Medicare cost growth declining relative to private health care cost growth, and even relative to per-capita GDP growth, over the long term. As Trustees we are not in a position to predict the future actions of lawmakers, and most of the Trustees' report is devoted to projecting the course of future program finances under current law as written.

That said, the Trustees' report does note that under current law, Medicare physician payments would be cut by roughly 25% at the start of 2014 under the Sustainable Growth Rate (SGR) payment formula, and that lawmakers have overridden the SGR in each year since 2003. While our primary projection assumes that current law will be maintained and that the physician payment will take effect, we also show an illustrative alternative scenario in which scheduled SGR reductions are overridden so that future payment increases reflect the average physician fee payment updates that occurred from 2004 to 2013. Under this scenario total Medicare costs are more than 10% higher over the long term, reaching 7.2 percent of GDP in 2087 as opposed to 6.5 percent under current law. We also show a second illustrative alternative scenario in which, in addition to overriding the SGR, certain cost-saving provisions of the ACA are phased partially out over the years 2020-2034. Under this second alternative scenario total Medicare costs would reach 9.8 percent of GDP by 2087.

Total Medicare Costs as a % of GDP, Current Law and Illustrative Alternative Scenarios



The inclusion of these illustrative alternative scenarios should not be interpreted as a prediction or a policy recommendation by the Trustees. The historical pattern of SGR overrides, however, is by itself an indication that actual Medicare costs are likely to be higher than we are currently projecting.

Conclusion

Medicare is a complex program in which financing strains are manifested in phenomena ranging from the projected date of depletion of its HI Trust Fund to the rising pressure that growth in SMI expenditures will exert upon the general federal budget. Over the next few decades costs are projected to rise at rates significantly faster than GDP growth primarily due to the rising number of program beneficiaries. Thereafter the rate of program cost growth will be influenced to a significant extent by general health cost inflation. Projections of Medicare cost growth are subject to considerable uncertainty especially over the long term, but costs are likely to be higher than under current projections if lawmakers continue the historical pattern of overriding current-law physician payment reductions under the SGR formula. Under our current projections legislation will be needed to prevent a financing shortfall in Medicare HI and to address rising budgetary pressures arising from Medicare SMI. The sooner such legislation is enacted, the more gradual can be its effects and the greater the potential for long-term savings.